STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	010235	A. BUILDING: _____ B. WING _____	06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR ASSISTED LIVING OF FORT WAYNE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: June 25 and 26, 2014 Facility number: 010235 Survey team: Diane Nilson, RN, TC Tim Long, RN, June 26,2014 Carol Miller, RN, June 26, 2014 Census bed type: Residential: 60 Census payor type: Private: 60 Sample: 7 Harbour Assisted Living of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality Review 06/27/14 by Lisa McColly	R 000		